The Treatment of Drinking Problems

A guide for the helping professions

Fourth Edition

Griffith Edwards

CBE, DSc, DM, FRCP, FRCPsych (Hon), F Med Sci National Addiction Centre, London

E. Jane Marshall

MRCP(I), MRCPsych, National Addiction Centre, London

Christopher C.H. Cook

MD, MRCPsych, Kent Institute of Medicine and Health Sciences, Canterbury

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The history of treatment for drinking problems

What professional assistance could a man or woman suffering from a drinking problem have expected to receive in the distant or more recent past? A look at that question may help towards understanding the origins of present ideas and practices in the alcohol treatment arena. It is the history of ideas as much as of practices which needs to be examined – the underlying assumptions make what happens in the clinical encounter.

The structure of this chapter is as follows. The pre-history of treatment is first briefly considered. The roots of formal medical intervention probably developed at the end of the eighteenth and beginning of the nineteenth centuries as products of the European enlightenment, and certain founding texts from that era are examined. From then onwards, there is the evolving history to be told of ideas shaped by their age, and practices shaped by those ideas.

Alcohol problems and the pre-history of treatment

There were over time two historically distinct disease movements in the alcohol field. Those authorities who separately in the nineteenth (Kerr, 1887; Crothers, 1893) and then in the twentieth century (Jellinek, 1960) championed the idea of alcoholism as a disease, in each instance saw the concept as opening the way to benign and scientifically based treatment of the drinker. They tended to contrast the modernism of their formulations with the dark previous centuries during which excessive drinking had been deemed a sin, and had been the province of moralism and the clergy.

Such dismissiveness sold too short the ancient role of the Church in dealing with drinking problems. Over those earlier centuries Christianity gave Europe an all-inclusive framework within which to comprehend and respond to aberrant human behaviour. Unsurprisingly, drinking problems found themselves located within that general frame.

Thus drunkenness was from the days of the early Church preached against and denounced as sinful, with that view fully congruent with the governing images of contemporary life. It was within the power of the sinner to repent and stop sinning without recourse to a doctor. Self-determined change was demanded of the individual and prayed for. The Church developed graded scales of penance to be meted out according to the degree of drunkenness and the position of the drinker within the Church hierarchy – laymen were let off relatively lightly and drunken bishops fared the worst (Edwards, 2000).

The dark days were in fact far from pitch dark, and the Church's response to drunkenness had within it psychological principles of some sophistication. The recent burgeoning of research interest in natural or spontaneous recovery (Klingemann et al., 2001) may help towards a reappraisal of the influence which Christianity and other religions may exert on drinking norms and drinking behaviour. Traditional Jewish mores have been very effective in curbing drunkenness (Snyder, 1958), while Islam has prohibited alcohol (Baasher, 1983).

A brave new dawn

Benjamin Rush (1743–1813) was an American physician who had attended Edinburgh for postgraduate studies. In 1790 he published a pamphet entitled 'An Inquiry into the Effects of Ardent Spirits . . . ' (Rush, 1790). He was a signatory to the Declaration of Independence. In 1804, Thomas Trotter, an Edinburgh-trained doctor who served as a ship's surgeon and in his spare time wrote poetry, published an essay on drunkenness (Trotter, 1804). The ideas which these two men developed were congruent with the thinking of the Age of Reason. Drunkenness was for them not a sin but a habit to be unlearnt. As Trotter pithily put it, 'The habit of drunkenness is a disease of the mind.' The key terms employed in that statement had meanings somewhat different from their modern usage. But the message that sin was out of the equation, drunkenness a rationally explicable behaviour, and that medical interventions were to derive from explanations of cause, transcends language and time. This was revolutionary thinking.

BOX 1.1

The habit of drunkenness is a disease of the mind.
Thomas Trotter (1804).

Here is a passage from Rush which shows that idea being taken through to practice:

Our knowledge of the principle of association upon the minds and conducts of men, should lead us to destroy, by other impressions, the influence of all these circumstances, with which recollection and desire of spirits are combined . . . Now by finding a new and interesting employment, or subject of conversation for drunkards, at the usual times in which they have been accustomed to drink . . . their habits of intemperance can be completely destroyed.

This is Trotter purposively distancing himself from the religious past:

The priesthood have poured forth its anathemas from the pulpit, and the moralist, no less severe, hath declaimed against it as a vice degrading to our nature. Both have meant well . . . But the physical influence of custom, confirmed into habit, interwoven with the actions of our sentient system, and reacting on our mental part, have been entirely forgotten.

Rush achieved greater contemporary fame than Trotter, and his *Inquiry* was taken up as a founding text by the Temperance movement. Trotter was, however, the more sensitive clinician, and his *Essay* deserves recognition as the first significant text on the treatment of drinking problems to be published in the English language (it was originally presented in Latin as an Edinburgh MD thesis).

Temperance movements

There is no evidence that Rush's or Trotter's clinical teachings were in their own time ever taken up on a large scale by practitioners. Over most of the nineteenth century the old religious approach continued to operate, with many denunciations from the pulpit still heard. However, over this period the Temperance movement came into being (Blocker, 1989). Temperance was a lay movement which had alliances at times with most of the Christian denominations and particularly strong connections with the Free Churches. It is remembered today for its mass teaching of abstinence, but help was often given to the individual drinker. The reformed drunkard was the show piece at public meetings. Vividly presented accounts of drunken degradation and eventual salvation could be the best show in town (Crowley, 1999). Within the movement, the former inebriate could expect to find esteem and a new identity.

The Washingtonian Temperance Society, founded in Baltimore in 1840, had within it a strong element of self-help and has been seen as the forerunner of Alcoholics Anonymous (Maxwell, 1950). This is the pledge which the six founding members of the movement took one evening in a down-town Baltimore tavern:

We, whose names are annexed, desirous of forming a society for our mutual benefit and to guard against a pernicious practice which is injurious to our health, standing, and families, do pledge ourselves as gentlemen that we will not drink any spirituous or malt liquors, wine or cider.

The Baltimore tavern-keeper was soon complaining about the loss of some of his best customers. The power of mutuality in aiding recovery from alcohol dependence had been discovered – that phrase 'a society for our mutual benefit' was crucial. The clergy, however, objected that reformed drunkards were usurping the leadership of an organization which properly belonged to the cloth, and the Washingtonians flourished only for a few years as a distinct organizational entity.

Another variant of nineteenth century, lay help for the individual drinker, can be seen in the work of the Salvation Army and the writings of its founder, William Booth (Booth, 1890). Booth was a Christian social reformer and acutely aware that much of the rampant drunkenness of Victorian cities was the product of the appalling living conditions of the urban poor. He described alcohol as 'the Lethe of the miserable'. Evangelical Christianity was one important ingredient of the Salvationist approach to the man or woman in the gutter, but there was also a strong emphasis on giving practical help and on environmental remedies. The drunkard might very literally be offered a way out of the drink-sodden urban trap, a place in a Harbour Light home, or a ticket to a Farm Colony overseas.

Institutions find favour

In the 1870s a vigorous movement was launched in America which pressed for the establishment of inebriate asylums to which troubled drinkers were to be admitted for anything between 5 or 10 years and life. This model was advocated in a manifesto put out by the American Society for the Study and Cure of Inebriety (Crothers, 1893):

> . . . the great centres of pauperism and criminality will be broken up. This will be accomplished by the establishment of work-house hospitals, where the inebriate can be treated and restrained. Such places must be located in the country, removed from large cities and towns, and conducted on a military basis . . . They should be military training hospitals, where all the surroundings are under the exact care of the physician, and every condition of life is regulated with steady uniformity.

If secure institutional separation from drink was to be the major part of the later nineteenth-century cure plan whatever the social class, the well-heeled would receive the added benefits of tonics, steam baths and faradic stimulation – the logic for these physical treatments was vaguely stated in terms of toning up the nerve cells. Even leeches might find favour. For the professional classes there would probably also be daily prayers, supervised country walks, musical evenings, and access to a library and a billiard table.

The institutional movement was medically led, but, despite the talk of medicine and science, it was for the working classes considerably more punitive than anything the Church would have favoured in the supposedly dark past. In the private homes, moral regeneration was intrinsic to the plan. In short, medicalization and stark moralism at this time often went nicely hand in hand. The psychological subtlety of the Rush and Trotter analyses had gone.

The institutional treatment formula had become discredited by the time of the First World War. Not enough clients could be found for the private retreats and the state reformatories were proving to be ineffective and expensive, and were becoming clogged with irrecoverable cases. The inebriate institutions were congruent with the disease theory, with fear of degeneration, and with belief in the validity of incarceration as a response to perceived social threats of various different kinds.

From that era two books remain as prime enshrinement of medical thinking on the institutional treatment of inebriety. Crothers (1893) produced the authoritative American text, while Norman Kerr (1887) wrote an encyclopaedic British text which went through three editions. Kerr was the first president of the British Society for the Study and Cure of Inebriety, which has come through to the present as the Society for the Study of Addiction, while the Proceedings of the Society go forward as the journal *Addiction*. The American Society and its journal had their *raìson d'être* removed by Prohibition. The twentieth-century experts who later promulgated the new disease concept were to an astonishing degree amnesic to those nineteenth-century events.

By 1900 – so far, what?

Choosing the turning of centuries as the markers for this analysis is to an extent arbitrary. But by 1900 the Western world, with its deep background of a sin model and the religious response to the drunkard, had accumulated 100 years of experience with variants of a disease model, and the medical claim to ownership of the problem. Certain major stands in the allegedly post-sin response to inebriety had begun to emerge (see Box 1.2).

BOX 1.2 **Some major strands in the history of treatment for drinking problems**

- Demarcation of case from not case
- The problem as habit
- The enthusiasm for physical treatments
- Institutions much advocated
- Treatment never a medical monopoly

- Not every excessive drinker had automatically become a suitable case for medical treatment. The legitimate medical cases were the drinkers who suffered from an imprecise disease state which was designated *inebriety*, and which was a brain disease with a hereditary element in its aetiology. Common drunkenness was not the doctor's business.
- A view of the problem as habit and treatment as the breaking of habit – the forerunner of the cognitive–behavioural analysis – had been put on offer at the beginning of the century, but did not appeal to the Victorian disease theorists.
- Physical treatments, often of a blindly empirical nature, were being employed.
- Doctors had become champions of institutions and of a milieu approach. They also often became directors or owners of these institutions.
- People who were not doctors were, through the Temperance movement, a continuing part of the response system.

To a remarkable degree, those five strands which had emerged in the nineteenth century were carried through, explored and re-explored as the dominant themes of the twentieth-century treatment endeavour. We will use them as sub-headings for the next section.

The twentieth century and five themes carried forward

Defining who and what needed treatment

For Trotter there was no term available to differentiate case from not case – his essay was on 'drunkenness', rather than on a specific type of diseased person. Come the latter part of the nineteenth century, experts in both the USA and the UK employed the word 'inebriety' to identify an overarching condition, with sub-types defined by the substances involved. Inebriety was thus for Kerr (1887) and Crothers (1893) a generic term roughly equivalent to today's DSM-IV (American Psychiatric Association, 1994), or ICD-10 'dependence' (World Health Organization, 1992). At that time, the word 'addiction' still had only limited currency.

Come the early decades of the nineteenth century and the word 'alcoholic' was quite often being used by medical authorities, but not with any great precision (it had first been introduced as *alcoholismus* by Magnus Huss, a Swedish physician, in 1849). There had been a slow lead-up to that position, but the definitive confirmation that the new nomenclature had won came in 1960 with the publication of E.M. Jellinek's *The Disease Concept of Alcoholism* (Jellinek, 1960). Alcoholism, according to Jellinek, could have its sub-types which were either disease or not disease. But in common medical usage from 1960 onwards, the disease of alcoholism separated the domain of medicine and the worthy sick person from the wasteland of common and unworthy drunkenness. Alcoholism was a disease and a progressive

disease (Jellinek, 1952) and the only way for the sufferer to arrest its progression was to espouse life-long abstinence. Jellinek's disease of alcoholism was, however, never operationally defined.

Why worry about words? The word 'alcoholism' mattered because it came to imply that, within this new deal, the only problem was the patient experiencing loss of control over their drinking – the person who had severe withdrawal symptoms, the advanced case, the one stereotype. This 'alcoholism' concept gave an entry to medical treatment and to insurance cover for many people who previously would have been given no help at all, and it was benign in many of its consequences. But at the same time it invited a tunnel vision. The boundaries of the treatment effort and service provision, and of the public health response, were dictated by the one potent word. The person who was drinking enough to harm their health or social well-being, but who did not conform to the stereotype, was left off the helping map. Help had always to be an intensive business, conducted at the start most often in an in-patient setting, but with the help of Alcoholics Anonymous (AA). Aftercare also had to be intensive, with continued AA attendance seen as mandatory. We return to the history of AA shortly.

When survey research began to show that there were particulate problems with alcohol which were widely disseminated in the population and did not conform to the picture of the disease state (Room, 1977), treatment services in some countries began to broaden their focus, with a new emphasis on brief or early intervention in the primary care (Wallace et al., 1988) or general hospital setting (Chick et al., 1985). In North America, that re-focusing has not been so apparent as in Britain and Australia. The American treatment service discourse is still largely about 'the alcoholic' and the provision of specialist care for the dependent drinker (Galanter, 2000).

In 1977 a new conceptual framework was promulgated by the World Health Organization (WHO; Edwards, 1976), which has since won a good deal of international acceptance. This entailed a two-dimensional framework for understanding troubled drinking, with alcohol dependence conceptually distinguished from alcohol-related problems. Within that view the suitable case for treatment becomes anyone who wants help with their drinking, whether or not they are dependent on alcohol. The concept of alcohol dependence was sufficiently specified to allow operationalization (Stockwell et al., 1979).

The habit and treatment as the breaking of habit

Given the clear enunciation of a habit formulation by Rush and Trotter those years ago, it is surprising that the idea should have taken so long to come circling back again. The first re-awakening of interest in that kind of perspective occurred in 1930 when Kantorovitch, working in Russia, described an aversion therapy which

employed painful shock as the unconditioned stimulus (see Voegtlin and Lemere, 1950, for a review of the early literature on this topic). In the 1940s Voegtlin and Lemere, at the Shadel Sanatorium in Seattle, began to treat alcohol problems with aversion therapy (Lemere, 1987). Their approach was consciously derived from Pavlov. The conditioned stimulus (smell or sip of alcohol) was to be paired with an unconditioned stimulus (nausea induced by injection of emetine), with the intention of setting up a conditioned aversion to alcohol. A large number of patients were treated at the Shadel. In 1950 these authors reported on a series of 4096 subjects, with a claimed 60% abstinence at the 1-year point (Voegtlin and Lemere, 1950).

With the increasing deployment of psychological principles to the treatment of neurosis, it was a natural extension to apply behavioural and then cognitive methods to the treatment of drinking problems (Sobell and Sobell, 1973, 1976). A large body of research developed exploring the clinical application of the idea of bad drinking as a habit, which with suitable psychological input could be unlearnt (Heather and Robertson, 1981). Relapse was reformulated as a cue-engendered behaviour which could, with training, be extinguished (Marlatt and Gordon, 1985).

Two centuries after Trotter and Rush first signalled these ideas, cognitive–behavioural approaches to the treatment of the drinking habits are today strongly established elements within the treatment repertoire. The extent to which the theoretical underpinnings satisfactorily explain treatment effectiveness is still an open question, but the 200-year-old concept of excessive drinking as habit of the mind has proved to be an enduring and productive contribution to scientific thought, with fruitful follow-through to clinical practice.

The history of physical treatments

As seen with the traditional medical response to many other intractable conditions of unknown aetiology, before modern therapies and controlled trials came onto the scene every imaginable physical treatment was at one time or another thrown by doctors at drinking problems (Edwards, 2000). Here are a few examples of that kind of empiricism in action. Amphetamine sulphate, LSD, cannabis and maintenance doses of diazepam have all appeared in the literature as advised treatments for excessive drinking. Patients have been injected with their own serum to which whisky has been added. Carbon dioxide or oxygen injections have been given subcutaneously as a cure for inebriety. Electroconvulsive therapy (ECT) has been administered to the point of confusion. Brain operations have been performed as a cure for addiction to alcohol and other drugs. The prize for unsubstantiated enthusiasm might go to Shilo (1961). He devised a treatment regime involving the patient's consumption of precisely 231 lemons taken over an exact 29 days.

BOX 1.3 **The Lemon Cure**

To stamp out craving for alcohol take 231 lemons over 29 days precisely.
Shilo (1961)

Interest in the pharmacotherapy of drinking problems took a new turn with the introduction of disulfiram (Antabuse) to clinical practice in the 1940s (Hald and Jacobsen, 1948). Its launch pre-dated the dominance of scientific rules set by clinical trials, and disulfiram can perhaps be seen as a drug which rode at the tail-end of the age of empiricism rather than being a treatment timed to arrive at the forefront of rigorous controlled trials. A current appraisal of the place of disulfiram in therapeutics is given in Chapter 19. The new anti-craving drugs such as acamprosate and naltrexone (Chapter 19) are products of a different clinical and scientific era than the lemon cure.

Without negating the value of recent advances, history must suggest that therapists in this arena will do well to remember the uncomfortable past. Drug cures for the drinking habit are much to be welcomed, provided their worth is not talked up into being the simple and conclusive cure for a highly complex condition.

How the institutional treatment theme was carried forward

Astley Cooper (1913), medical superintendent and licensee of the Ghyllwood Sanatorium in Cumberland, stated in his textbook that 'Without fear of contradiction . . . we say that for the thorough treatment of inebriety, the special sanatorium stands alone.' Until well into the second half of the twentieth century, Astley Cooper's assertion was unlikely to have met with medical dissent. The treatment of inebriety in Europe and the USA was for many years still built on the teaching and practices of the 1870s, although the reformatories had been got out of the way. Treatment was offered to private patients in the traditional pleasant surroundings, while those without financial resources would find themselves shut away in state mental hospitals or asylums. Treatment of the disease of inebriety was for all comers still co-terminus with institutional care.

With the arrival following the Second World War of the concept of alcoholism as a disease, new impetus was given to institutional care. A mix of private and public provisions supported this intention. In the UK a crucial influence was exerted by the alcoholism treatment unit which had been opened within the National Health Service by Dr Max Glatt at Warlingham Park Hospital in the early 1950s (Glatt, 1955). A substantial in-patient stay was at first advocated as the routine, with patients bussed out to attend AA. This model was enthusiastically taken up by the British Department of Health with the intention that units of that kind would be established throughout the UK, as the lead element in response to the now needy

and deserving person suffering from the disease of alcoholism (Thom, 1999). The emphasis on group therapy was new, but otherwise what was seen as the therapeutic cutting edge was in fact to a large degree a recapitulation of earlier keenness for the institutional treatment of the inebriate.

In the USA, a development occurred from the 1970s onwards which emphasized a mix of in-patient care, milieu therapy and a Twelve Step (AA) approach, within what came to be referred to as the Minnesota Model (see Chapter 18). This regime rested squarely on the disease concept of alcoholism. From the late 1980s onwards, the popularity of this model was cramped by questions concerning cost-effectiveness, and by the imperatives of managed care (Galanter, 2000). Whatever the country, it is probably the economic imperatives rather than a change in theoretical orientation or the weight of research evidence that in today's treatment world have damped the ancient enthusiasm for the institution as remedy which stands alone.

Evolutions in the non-medical contribution to treatment

The twentieth-century evolutions in the non-medical contribution to the treatment of drinking problems have gone so far as to considerably change the face of the modern treatment enterprise.

A dominant influence of this type was seen in the evolution of AA from its small beginnings in 1933 as an off-shoot of the Oxford Group (an evangelical Christian sect) to an organization at present with a world-wide membership of over 2 million people (Kurtz, 1991). The influence of AA on shaping twentieth-century approaches to the treatment of alcohol dependence has been vast in terms of both setting ideas and determining practice (Edwards, 1996). It is a lay organization which has succeeded in powerfully shaping professional assumptions as to the nature of the condition being treated and the kind of treatment required – and all this although AA's primary and continuing impact is exerted through its group meetings and the help given to the next individual walking through the door.

Several historical strands can be seen as coming together in AA. Christianity is back in the picture, but without the clergy, and for some members of AA also without God. The ancient role model of 'reformed drunkard' is now the AA sponsor or the person who can capitalize on their experience to gain employment as a counsellor in a Twelve Step facility. The best show in town has been muted to become the still often gripping centrepiece of any AA meeting, the recovering alcoholic 'telling their story'.

If AA as transmitter of the ancient themes of repentance and redemption and salvation through faith has been one force shaping twentieth-century treatment, another powerful influence in the latter part of the twentieth century was the reincarnation of rationality seen in the influence of behavioural and cognitive

psychology (Gossop, 1996). When dependence is viewed as habit to be unlearnt, it is evidently the psychologists who should be called on as experts in that kind of work.

Thus today's highly important overall non-medical contributions to the treatment of drinking problems derive from traditions which enshrine historically very different views on the nature of the problem and the help which the inebriate needs.

History – what significance for today's clinic?

History is relevant to any and every modern practitioner in this field, in terms of the invitation it makes to ask oneself certain questions. Others may see different questions as salient, but here is one tentative list of ideas on what history might give to some reflections while waiting for the next patient to arrive at today's clinic.

- In what way do today's facilities define the suitable case for treatment? What overt or latent assumptions, administrative fiats or historical influences set the rules? Are they optimal?
- What rationality, productive contradictions, muddling through or historical lumber set the therapist's personal model of understanding as to the nature of the condition which will today be treated? Have we really worked that question out in our minds? What do we do with sin, free will, habit, disease and other conceptual legacies? Is that model shared with our fellow professionals or patients?
- In a historically changing scene, what is the contribution which any specific professional skills are best likely today to make? How do our efforts fit with the larger, ever-shifting totality of the professional and lay effort to help the person with a drinking problem?
- How congruent are our professional beliefs with the background cultural beliefs of a multi-ethnic society, with how anyone watching tonight's television is likely to understand human behaviour?

Perhaps also, if we have time after the clinic to look in the library at some of the founding texts, we may find that today's work can be enriched by a sense of fellowship with clinicians who sat waiting for their patients more distantly. Let's close this chapter by again going back to Trotter (1804):

> When inebriety has become so far habitual that some disease appears in consequence . . . it is in vain to prescribe for it till the evil genius of the habit has been subdued. On such an occasion it is difficult to lay down rules. The physician must be guided by his own discretion: he must scrutinise the character of his patient, his pursuits, his modes of living, his very passions and private affairs. He must consult his own experience of human nature, and what he has learnt in the school of the world. The great point to be obtained is the confidence of the sick man; but this is not to be accomplished at a first visit. It is to be remembered that a bodily infirmity is not the only thing to be corrected.

Then Trotter gives that absolute summing up of his understanding, with the italics found in the original:

The habit of drunkenness is a disease of the mind.

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